COMMITTEE ON MEDICAL AND HOSPITAL SERVICES OF THE ARMED FORCES

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Report of the Committee
on that part of its
assignment
relative to:

PROGRAMS FOR HOSPITALIZATION IN THE ARMED FORCES AND FOR IMPROVEMENT IN THE UTILIZATION OF EXISTING HOSPITAL FACILITIES

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OFFICE OF THE SECRETARY OF DEFENSE

TABLE OF CONTENTS

OFFICE OF THE SECRETARY OF DEFENSE
WASHINGTON

COMMITTEE ON MEDICAL AND HOSPITAL SERVICES OF THE ARMED FORCES

7 JAN 1949

To: The Secretary of Defense

Subject: Programs for Hospitalization in the Armed Forces and for Improvement in the Utilization of Existing Hospital Facilities

Reference: (a) Memorandum from Secretary of Defense to Dr. Paul R. Hawley, Chairman of the Committee on Medical and Hospital Services of the Armed Forces, dated 1 January 1948

1. By the instructions contained in Reference (a), you asked that among other problems the Committee give attention to:

> "Improvement in the utilization of the existing hospital facilities of the several medical services. This will include consideration of the number of hospital beds required in each geographical area to meet the collective needs of the three services, a study of which hospitals are so located as to make it feasible for them to serve more than one of the Departments, and a determination as to which hospitals, if any, should be closed, placed in standby status or disposed of as surplus. It will also require an examination and re-evaluation of the standards for hospitalization and an inquiry into the possibility of using other facilities, in lieu of regular hospitals, for minor convalescence, periodic medical examinations, etc. The problem of utilization of hospital facilities should also be considered in relation to the availability of qualified medical personnel, both general and specialized, and consideration should be given to the question of whether certain types of medical services required by the Armed Forces, generally, or in specific areas, could be performed more efficiently and economically by utilizing civilian hospital facilities that may be available."

and

> "Coordination of the current plans of the medical services of the Armed Forces for the construction of any new hospital facilities in the future, having in mind the type of considerations listed in a above, . . ."

7 JAN 1949

and

"Methods for improving the organization, management and administration of the several medical departments in the operation of both their hospital and medical programs, including the possibilities of consolidation or coordination of certain activities and functions thereof, and the reduction of the combined overheads of the medical services of the Armed Forces."

and

"Allocation to one service of the responsibility for providing all hospitalization and medical care for all services in certain fields of medicine, as for example, in the fields of tropical medicine, neuropsychiatry, radiological injuries, prosthetics, and serious disorders of the ear and eye."

and

"Development, to the highest practicable degree, of common standards, practices and procedures among the medical services of the Armed Forces with respect to . . . the organization, administration and operation of hospitals."

2. Some features of the matters mentioned above have been considered and reported upon by the Committee in previously submitted reports, inasmuch as the matter of hospitalization and hospital programs of the Armed Forces can not be completely isolated or considered as an independent problem apart from the many other inter-related and interdigitating features, functions and problems of the medical departments of the Armed Forces.

3. In its deliberations on the general problem of "hospitalization and hospital programs," which has numerous facets and far-reaching ramifications, the Committee has viewed the problem in the light of what it

considers to be the primary and paramount purposes of the Medical and Hospital Services of the Armed Forces. These are held to be:

(a) To provide the best possible medical treatment and care for the sick and injured personnel of the Armed Forces in peace or war.

(b) To promote the general physical fitness of personnel of the Armed Forces in peace or war through the prevention of disease and the maintenance of a high level of general health.

(c) To preserve the physical well-being and military effectiveness of the personnel of the Armed Forces through research in, supervision of, and constant vigilance over measures designed to protect these personnel against environments unfavorable to health and against special physical and health hazards to which they as members of the Armed Forces may be subjected.

(d) To plan, develop, train, and organize the medical departments in time of peace so as to be most readily adaptable for speedy transition to a national emergency basis and best prepared for the administration and operation in time of war of greatly expanded various medical services which would then be required in support of the Armed Forces. All endeavors and programs of the Medical Departments must therefore be tested against these four governing purposes, and no hospitalization program or plan can be excepted from the foregoing fundamental principles.

4. In its analysis of the hospitalization requirements, the Committee has availed itself of the assistance of a Subcommittee on Programs for

Hospitalization, appointed by the Committee in consonance with paragraph 4 of Reference (a). As a further basis for analysing and evaluating the problems indicated in paragraph 1 above, the Committee has, during the past eleven months, visited a majority of the hospitals and other medical installations of the Armed Forces both within the continental United States and overseas.

5. The anticipated requirements for medical services and hospitalization during the next 18 months (through Fiscal Year 1950) have been taken as the principal basis upon which to predicate any plans or proposals which may be recommended with a view to improving the utilization of existing Armed Forces hospital facilities. This involves consideration not only of the total projected personnel strengths of the Army, Navy, and Air Force which are currently expected to be attained during the Fiscal Year 1950, but also the probable geographic distribution of these total strengths. It is fully appreciated that these planned troop strengths and their anticipated geographic distribution are subject to future change, and that the plans and programs for hospitalization must retain a corresponding degree of latitude and flexibility to permit adjustment to such possible changes. The problem is further complicated by the fact that the principles of sound military and economic doctrine dictate that, in addition to taking the foregoing considerations into full account, the Committee must also view the problem from the standpoint indicated in the following paragraph.

6. The final conclusions and recommendation of the Committee in regard to the subject are tempered by the ever-present realization that the hospital programs and hospitalization plans and policies of the Armed Forces must always be such as will not only contribute most toward the best possible full medical support of all elements of the Armed Forces in peacetime, but also that these plans, policies and programs should be capable of ready adaptation and rapid expansion to assist in providing for the increased immediate needs of the Armed Forces which would suddenly arise in case of mobilization or armed conflict. It is recognized that, in practical and realistic consideration of the problem, some compromise must be made between the ideal which would obtain for either of these two conditions if each were to be considered alone and without any thought for the other, i.e., (1) plans and programs to meet purely peacetime requirements and (2) the suitability and adaptability of hospitalization plans and programs to meet the suddenly increased requirements in case of war or rapid large-scale mobilization.

7. The Committee holds that the Medical Departments of the Armed Forces, in order to most efficiently and most effectively perform those of its functions and responsibilities in support of the Armed Forces which may be classified under the broad heading of "hospitalization," should in so far as possible be guided by the following principles and objectives:

(a) To provide and utilize hospitals and other medical facilities of the Armed Forces to furnish medical care and treatment on a basis that will facilitate and expedite the restoration to an effective duty

status as quickly as possible of as many as possible of those who may become sick or injured.

(b) Without sacrificing the foregoing principle and objective, to afford the highest possible level of professional medical treatment to all the sick and injured of the Armed Forces.

(c) Without doing an injustice to any person who is now or has been a member of the Armed Forces, and having due regard for humanitarian considerations, to make the earliest possible appropriate disposition of those military patients in whose cases it has been determined that because of physical incapacity or mental disorder their restoration to active military duty is not possible.

8. The fullest possible attainment of the desirable objective set forth in subparagraph 7(a) above will materially contribute to the conservation of effective military manpower strength (through reduction of the non-effective rate due to period of absence from command because of sickness). This is illustrated by the fact that by achieving a reduction of only one day in the average time which each sick or injured member of the Armed Forces is absent from duty on each admission to the sick list, and at the current rate of admissions to the sick list, a total manpower conservation of approximately 1300 effective man-years per 1,000,000 total strength is realized. This end can be aided when as much as possible of the required hospitalization is provided as near as practicable to the immediate source from which the sick and injured come. Incidental savings in transportation costs and transportation facilities will also be realized as the result of any possible

decrease which can be effected in the number of patients requiring transfer to a hospital distant from their command, and as a result of reducing to the minimum the distance to which such patients need be transferred. The foregoing is also in consonance with the well recognized truth that the real worth of medical care is, in the final analysis, to be judged on the basis of how useful and satisfactory that medical care is to the community and individuals whom it serves. In general, the less accessible and the less readily available the required medical care becomes, the less suitable and the less satisfactory that service becomes to the population served.

9. In connection with subparagraph 7(c) above, the Committee is not unmindful of the problems and difficulties experienced in effecting appropriate disposition of such military patients, especially when upon their separation from the Armed Forces by reason of physical incapacity they require continued medical care and hospitalization. The magnitude of this ever-present problem is more fully appreciated when it is recalled that in the field of psychiatric disabilities alone, approximately 1500 patients with definite psychoses develop annually in a total military strength of 1,500,000 personnel. Similarly, patients with active tuberculosis constitute another large group. The Committee holds the view that all patients requiring further treatment, hospitalization or institutional or domiciliary care should, upon their discharge from the Armed Forces, be promptly transferred to the cognizance and responsibility of the Veterans Administration. It is appreciated, however, that this matter is indeed a difficult and exceedingly complex one, complicated as it is by a variety of governing laws and applicable administrative regulations and interpretations. Moreover, it is fully recognized that the degree to which the above can be accomplished at present is limited by several factors beyond the immediate control of

either the Veterans Administration or the Armed Forces. Taken collectively, these factors operate to create a continuing backlog of long-term and "supernumerary" patients in military hospitals. One such factor is the increasing number of patients from whom the Veterans Administration lacks legal authority to assume responsibility for medical care and hospitalization, notably those who have had no "wartime" military service which would qualify them for treatment and hospitalization as "veterans" for disabilities not incurred in the line of duty or is determined to have existed prior to entry into and not aggravated as a result of military service. *(See footnote.) This will become an increasingly recurrent problem, particularly in respect to such hospital patients who first entered the Armed Forces subsequent to 31 December 1946. The only recourse which can be followed at present by the Armed Forces in the disposition of such hospital patients lies in attempting to arrange for their disposition to the custody of relatives, charitable organizations or state or municipal medical institutions. Very frequently relatives and state or municipal activities are unable or unwilling to accept these patients, especially if they are psychotic or suffering from tuberculosis. In any event, several months commonly elapses before the disposition of such patients can be culminated. The enactment of enabling legislation which would alleviate this particular problem, and an increase in the facilities of the Veterans Administration to care for such chronic and long-term patients immediately upon their discharge from the Armed Forces, would facilitate a reduction in the "supernumerary" patient load in Armed Forces hospitals.

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*(Footnote). The Committee wishes to point out that hospitalization in military hospitals of ex-service personnel as Veterans Administration beneficiaries is done and can only be done on a reimbursable basis and then only on the specific request and authorization of the Veterans Administration in each individual case. Since 1920, the Army and Navy, on annual request of the Veterans Administration, have allocated a number of beds for authorized Veterans Administration patients in certain Armed Forces hospitals at locations where the Veterans Administration has insufficient or no hospital facilities.

10. Study of the broad problem covered by the subject of this report has involved careful consideration as to what would be the nature and structure of the best over-all plan for providing hospitalization for the Armed Forces. This, in turn, is only possible of determination on the basis of a realistic evaluation of what would be practicable and workable from the standpoint of the present organizational structure of the National Military Establishment as prescribed by the National Security Act of 1947. In the absence of a single military command organizational structure throughout the National Military Establishment, any acceptable hospitalization plan for the immediately foreseeable future must, therefore, be attuned to the needs of the three Departments of the Military Establishment which are largely autonomous in respect to their administration and as to their operation in the performance of their assigned missions.

11. It is a fundamental military concept that appropriate medical support must in some acceptable manner be provided for each military command, whether large or small, and for every individual military unit. Plans and programs for providing hospitalization for the Armed Forces must be evolved with a full appreciation of the fact that "hospitalization" is only one part of the medical service which is required and must be provided to meet the medical needs of the many individual posts, camps, bases, stations, and activities of the Army, Navy, and Air Force. The medical departments of the Armed Forces have no control over the number, location or geographical distribution of these numerous military activities.

In the continental limits of the United States alone these are widely dispersed among many scores of localities. At each and every one of these many individual Army, Navy, and Air Force activities some minimum level of medical coverage and of available medical service must be provided and maintained locally in order to sustain the local military establishment. The Committee considers it practicable that at many locations where two or more separate military installations or local military commands are situated near each other, some degree of the local medical service required by one military installation can be satisfactorily performed at or by the medical department of another nearby activity.

12. Before proceeding to the more detailed conclusions and recommendations of the Committee, it is deemed fitting to attempt to clarify for the reviewing authorities certain aspects of the meaning of the following terms used in connection with consideration of this subject:

(a) The term "ARMY TYPE DISPENSARY" as used in this report for purposes of functional description, connotes that no hospitalization or definitive "in-patient" treatment and care is performed in that facility. "Army type dispensaries" may have a very few beds where patients may remain until determination is made as to whether or not hospitalization is indicated, but such beds are not used for definitive treatment.

(b) The term "NAVY DISPENSARY" as currently used, denotes a Naval medical activity at which some degree of definitive in-patient care and treatment may or may not be performed, depending on the local need and

whether or not the "dispensary" has facilities to provide "in-patient" care. The Navy Dispensaries listed later in this report as recommended by the Committee for change or conversion of their functions to the nature of those performed at an "Army Type Dispensary," are among those "Navy Dispensaries" which now perform some degree of "in-patient" treatment or care. In essence, therefore, the conversion of certain Navy dispensaries to "Army type dispensaries" involves a change in the scope of their functions to the extent of discontinuing the performance of "in-patient" treatment and care at these Navy dispensaries.

(c) The term "STATION HOSPITAL" denotes an Army or Air Force medical facility which is equipped and staffed to provide medical, surgical and dental care for minor illnesses and injuries, including emergency treatment in case of accidents at the station, post, camp, base or area where the hospital is located. A Station Hospital normally receives its patients from dispensaries at or in the vicinity of the station where it is located, or from a dispensary "out-patient" service operated in conjunction with the Station Hospital.

(d) A "GENERAL HOSPITAL" is an Army medical facility especially staffed and equipped to provide medical, surgical and dental care for patients with diseases which are especially difficult to diagnose or with major conditions which require long periods of observation and definitive treatment, and for patients whose conditions require highly specialized or complicated treatment. Patients evacuated from overseas and those received from Station Hospitals within the continental United States are

the source of patients in a General Hospital. Where a General Hospital is located at a post, camp, or station, it also provides the station hospital type in-patient care for troops from the post, camp, or station.

(e) A "NAVAL HOSPITAL" is a Naval medical facility which may in general be comparable to either an Army Station Hospital or to an Army General Hospital, depending upon the size, staff, and facilities of an individual Naval Hospital. The size, staff, and facilities of each individual Naval Hospital are determined and provided on the basis of the particular needs and missions of that particular hospital, and depending upon whether the hospital is so situated and operated that it serves only the local Naval population (which may be relatively small, medium, or large in number), or whether in addition it is utilized also to serve a much wider geographical area and a greater Naval population to the extent of providing specialized medical or surgical care for selected patients having diseases or conditions of a more serious or complicated nature and requiring highly specialized or more extensive definitive treatment. Naval hospitals receive their patients from the dispensaries of Naval commands in the area, from Naval forces afloat in the area, from fleets and Naval shore activities overseas, and from other Naval Hospitals not adequately staffed or equipped to provide appropriate care and treatment for selected patients suffering from the more serious, more obscure, more complicated or more specialized diseases and conditions.

13. Both the Army type dispensaries and the Navy dispensaries (and most Station Hospitals) constitute the only available local office and facilities

for the individual post or station medical department. These are required and necessary for performance of those medical functions which are essential to the local military command, whether or not "in-patient" treatment is provided therein. At both Army and Navy dispensaries the bulk of the necessary routine and special physical examinations are conducted - both for military personnel and for civilian employees in connection with their employment. It is here also that "sick-call" is regularly conducted, and medical screening accomplished to determine whether or not the ailment or physical condition of individuals is such as to require hospitalization. Out-patient treatment is provided by the dispensaries for personnel whose ailment is such that they may receive appropriate treatment and observation while continuing on a "duty status." Functionsof the local medical department of a post or station having to do with sanitation and preventive medicine including industrial health programs, are also performed in and from the dispensary (Station Hospital in many instances). The dispensaries or Station Hospitals also provide the local medical facilities at the several posts, camps, and stations required to be readily available for the initial emergency treatment of major and minor injuries in case of local disaster, accident or airplane crash. Dispensaries, and the medical functions performed thereat, thus fulfill an important role in relation to the hospital system by reducing the routine medical department work-load which hospitals would otherwise be obliged to shoulder, and by limiting the in-flow of patients to the

hospitals wherein more definitive treatment is afforded for those patients requiring it.

14. In its review of this whole problem of improvement in the utilization of hospital facilities of the Armed Forces, the Committee has examined and evaluated the standards employed for hospitalization of personnel of the Army, Navy, and Air Force. For many years the Armed Forces, the Congress, and the American people have been in accord in the determination that within the medical means available the men and women serving in the Armed Forces shall be provided with the very best of medical care and attention which it is possible to afford them. The Committee does not believe that the present standards for medical care and hospitalization in the Armed Forces are too high, nor that any appreciable lowering of these standards could be brought about without serious effect on the morale and operational efficiency of the Armed Forces as a whole. Hospitalization or "in-patient" treatment and care of some type must be provided for all persons in the Armed Forces who, by reason of any ailment, are unable to continue to perform their work on a duty status. Even those who are only partially incapacitated for physical reasons must be attended by a medical officer, must be properly accounted for as being on the sick list, and must remain under medical observation and supervision until fully able to resume duty. There is no problem comparable to this in civilian life or in civilian medical and hospital practice. The average civilian who is not seriously ill,

and who may or may not be seen by the family physician is not placed in a hospital but is provided food, shelter, nursing care and some degree of medical treatment at his own home by members of his own family, with or without guidance from a doctor. In the military Services, the proper place for such individuals who, by reason of some disease or physical condition, are unable to be on duty and at their work, is in a medical facility where they can be closely observed and cared for by the medical department until they are again fully able to resume their usual work and duties. Experience over many years has demonstrated that such is not only necessary in the best interests of military efficiency and in protecting the interests of both the government and the ailing individual, but also in the practice of good public health medicine in preventing the spread of contagious or communicable diseases among other members of the command. The average civilian who is hospitalized and who is suffering from some major illness or some condition requiring surgical intervention or a period of treatment in a civilian hospital, is usually released from the hospital to his home as soon as his condition is such as to permit further recovery and convalescence to be accomplished there. Such policies and procedures are not practicable or possible of being followed in the military Services.

15. The Committee has considered the question of whether certain types of medical services and hospitalization could be performed more efficiently and more economically by utilizing civilian hospital facilities.

Civilian hospitals and non-military hospitals of the Federal government are occasionally utilized for hospitalizing members of the Armed Forces when there are no military hospitals available in the vicinity, and until such time as the patient's condition permits his transfer to a military hospital. Occasions where members of the military forces are injured or become ill while on leave or in transit where medical facilities of the Armed Forces are not immediately available, and those few exceptional cases in which (by reason of the very special or unusual nature of the patient's disease or condition) suitable treatment can for some special reason be more appropriately provided in some selected civilian medical facility, constitute the relatively small percentage of patients of the Armed Forces who are hospitalized in civilian hospital facilities. Experience has indicated that only as long as this total number remains very small and relatively insignificant, can the associated administrative problems be satisfactorily handled. The attending problems encountered in meeting the administrative and legal requirements of the Armed Forces would, however, be tremendous and productive of chaotic situations should any considerable percentage of the total hospitalization of military patients be undertaken by civilian or non-military hospitals. Among such problems and difficulties may be mentioned the preparation and submission of the necessary and proper medical records and reports on each individual military patient, insuring that the military patients receive their military pay when due them, matters related to

military welfare and discipline, and the disposition of military patients after having received the maximum benefits of hospitalization. As to whether or not utilization by the Armed Forces of civilian medical services and hospital facilities would be more economical, information as to experienced cost to the government where certain types of medical service have been obtained on a considerable scale from civilian sources on a fee or contract basis indicates that such is much more expensive than would be the case could similar services be furnished in government facilities and by salaried professional personnel in the government service.

16. The question of the possible allocation to one Service of the responsibility for providing all hospitalization for all three Services in certain special fields of medicine, e.g., neuropsychiatry, tuberculosis, malignant neoplastic diseases, plastic and neurosurgery, etc., has been given deliberate consideration by the Committee. While it is recognized as essential that the best possible utilization be made in the Armed Forces of professional personnel who are highly qualified in certain special fields of medicine and surgery it is also essential that each Service continue to have among the medical officers serving therein a number of doctors and other medical personnel trained and experienced in these special fields. Further, that opportunity must be preserved for aspiring doctors serving with each of the three Armed Forces to obtain experience and training and to pursue clinical professional work in any one of these

special fields for which they may manifest a particular interest and aptitude. These desirable objectives can best be attained, and at the same time accomplish a consolidation into selected hospitals of the Armed Forces of patients from all three Services in certain special fields of medicine and surgery in the manner previously recommended and reviewed below. In the recommendations contained in its report on "Medical Professional Service in the Armed Forces," submitted 20 July 1948, the Committee recommended in the foregoing connection that:

> "Specialized Diagnostic and Treatment Centers be designated or established in connection with and as a part of selected General or Naval Hospitals for the hospitalization and definitive care of patients from all three Services in certain special fields of medicine, where such is considered appropriate and feasible. In this connection, it is to be emphasized that necessity exists for maintaining a general hospital service at each hospital having such a Specialized Diagnostic and Treatment Center where a concentration of patients of a particular medical category is made. In connection with this recommendation, it is the sense of the Committee that at the present time, sufficient and appropriate indication exists for such Specialized Diagnostic and Treatment Centers in only a small number of medical fields; for example, for patients in the field of tuberculosis, for those in the field of psychiatric and neuropsychiatric diseases and conditions, for those in the field of plastic and neurosurgery, and for those in the field of amputation rehabilitation and prosthetics."

The Committee further recommended in the aforementioned report that:

> "The principles of joint professional staffing by medical personnel from the participating Departments of the Armed Forces be adopted in the professional staffing of any Specialized Diagnostic and Treatment Centers that may be designated or established along the lines recommended above."

The Committee reiterates and reaffirms the foregoing recommendations, which are now in the process of consideration for approval by the Secretary of

Defense. It is the opinion of the Committee that, as an initial undertaking along this line, the first such joint Center which should be designated is one for psychotic and neuropsychiatric patients. The U. S. Naval Hospital, Houston, Texas, lends itself admirably for such utilization, and the necessary physical alterations to render a considerable portion of this hospital suitable for psychiatric patients have already been completed. It is the conclusion of the Committee that the appropriate facilities at the U. S. Naval Hospital, Houston, Texas, should be jointly utilized and jointly staffed for the foregoing purpose, and designated as a Specialized Diagnostic and Treatment Center for Psychotic Disorders and Neuropsychiatric Patients. *(See footnote).

17. The Committee is fully aware that the total existing potential bed-capacity (available constructed capacity) of some of the Naval Hospitals and Army General Hospitals recommended for continuation in active operation is in excess of the prospective required "authorized bed capacities" (functioning or operating capacities) of these hospitals during the next eighteen months. It is the Committee's firm conviction, however, that to recommend closure and/or disestablishment of any of these remaining

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*(Footnote). Since this conclusion relative to joint utilization of the U. S. Naval Hospital, Houston, Texas, for psychiatric patients was determined upon by the Committee, the President by Executive Order has directed that this hospital be transferred to the Veterans Administration for the latter's ownership, use, and operation.

hospitals of the Armed Forces (with the exception of those mentioned in paragraph 27 below) would be both militarily and economically unsound. It is axiomatic that the closing of hospitals does not reduce the total number of patients for whom hospitalization must somewhere be provided. Extensive closure of existing hospitals of the Armed Forces would increase the difficulty, logistic effort and cost of furnishing suitable hospitalization by necessitating the transfer or evacuation of larger numbers of patients to other hospitals more remotely located in relation to the sources from which such patients originated. It is the belief of the Committee that the favorable military and economic factors to be gained by continuing these hospitals in operation outweigh and would exceed any relatively small saving in personnel or funds which might be realized by closing them, even though at some of these hospitals the "constructed capacity" may exceed the presently required "authorized capacity" (approved operating capacity).

18. In these times of unsettled world conditions, the Committee would be remiss in the discharge of its responsibilities in the interest of national defense if, in considering this matter, it were not also to give the most careful thought to insuring the availability in reserve of a minimum of hospital capacities which will be required at the very beginning of any large scale mobilization of the Armed Forces for national emergency. The necessity for maintaining some ready reserve to insure that the initial requirements for military mobilization could be met is

well recognized and accepted nationally in respect to other types of essential material, equipment and facilities. The retention of this relatively small readily available reserve of hospital capacity -- which is represented by any difference between "constructed capacity" and the "authorized capacity" of the remaining Armed Forces hospitals -- constitutes such a reserve hospital capacity estimated as being sufficient only to meet the probable Armed Forces hospital requirements for about the first three months of mobilization. It would indeed be optimistic to expect that less than three (3) months would elapse after M-Day before increased hospital capacities to meet mobilization needs could otherwise be made ready for actual use through acquisition or construction of new hospital facilities -- however temporary in nature such new construction might be. Experience during the past three years has demonstrated that, with very few exceptions, it is most difficult to long retain Armed Forces hospitals in a standby or reserve status once they have been closed or disestablished. This is particularly true within the continental United States. As a general rule, such inactivated hospitals are soon lost for future Armed Forces hospital purposes through being taken over for conversion to some other permanent use by the Armed Forces, turned over to some other Department of the government, or disposed of to state, non-governmental, or civilian ownership for either medical, industrial, or commercial purposes. Any further substantial loss by the Armed Forces of existing constructed Armed Forces hospital facilities will therefore render it more uncertain

that the hospitalization requirements incident to the early months of mobilization could be met. Aside from the important military considerations mentioned above, the great cost which would be experienced by the government, in the event of mobilization or any large expansion of the Armed Forces, in rebuilding or otherwise acquiring at inflated costs an equivalent of this minimum of existing reserve hospital bed capacity would exceed many times the relatively small cost of retaining this existing "excess" (reserve) capacity at the respective hospitals for many years in a state of maintenance for ready reserve.

19. In giving consideration to the number and locations of General Hospitals and Naval Hospitals recommended for continuation in a status of active operation, the Committee has also taken cognizance of certain general principles which are quite generally accepted among experienced hospital administrators and hospital planners. It is generally recognized that the administration of a general medical and surgical hospital becomes more unwieldy and less efficient, and the personal relationship between patients and the professional staff as a whole becomes less satisfactory, if its functioning capacity exceeds 1000 to 1200 patients. The optimum operating size of individual general hospitals is, of course, influenced by several factors, such as: type of construction (i.e., whether contained in a number of buildings or in one compact building); the adequacy, location and nature of feeding facilities and other housekeeping services; the type of patients to be cared for (i.e., whether predominantly acute medical and surgical patients, resulting in a more rapid turnover of patient-load and a greater volume of administrative paper work and

other administrative procedures, or whether the hospital is to predominantly serve patients suffering from the more complicated or more chronic types of medical and surgical conditions); the adequacy of elevators and other intra-hospital traffic arrangements; and a wide variety of other factors. It has, however, been set forth by competent and well qualified authorities in this field that for general medical and surgical hospitals, the optimum bed capacity is approximately 1000, with 500 as the minimum and 1500 as the maximum capacities at which such hospitals should be planned and operated if greatest economy and efficiency is to be realized. The Committee is aware also of the current problem relative to the desirability of decentralization of major facilities of the Armed Forces for purposes of insuring a reasonable degree of dispersal and area distribution to best cope with any possible enemy bombing attack. This consideration further emphasizes the desirability and soundness of establishing and operating two hospitals at a reasonably safe distance from each other if the peace-time military needs in a particular geographical area require a total hospital capacity exceeding 1500 beds, rather than attempting to meet these total area requirements in one very large hospital.

20. The considerations mentioned in the preceding paragraph apply to plans for construction of any new hospital facilities of the Armed Forces in the future, as well as entering into the matter of determining what existing hospitals of the Armed Forces should be continued in active operation.

21. The Committee has devoted much consideration to the matter of estimating the maximum degree of consolidation of Armed Forces hospital facilities and of common or joint hospitalization which is feasible of accomplishment at this stage of unification of the Armed Forces without creating an inoperable state of chaotic confusion and a disastrous breakdown in the functioning of the military medical and hospital services. The Committee is impressed by a full realization of the fact that progress toward achieving the most desirable degree of uniformity, standardization and common utilization of hospital facilities which may ultimately be obtainable can only be made through the process of orderly transition. The rate and degree with which such change may be properly brought about is in turn influenced by the speed with which further standardization and uniformity is achieved in such basic matters as medical nomenclature, medical forms, medical records and medical reporting procedures, as well as in non-medical Departmental administrative practices and procedures. It is the considered opinion of the Committee that the recommendations contained in this report represent the maximum of joint or common hospitalization which should be undertaken at this time. The proposed undertaking in this field is of no smallmagnitude, involving as it does a much greater degree of common or joint hospitalization than ever before attempted by the Armed Forces. The feasibility of this undertaking is predicated upon concurrent approval and implementation of certain basic policies and procedures which are considered essential and vital to successful accomplishment of the enterprise: viz.,

(a) The assignment and detail of appropriate medical liaison and clerical personnel, from the Department whose patients are being provided in-patient care and treatment in the medical facility of another Department of the Armed Forces, for duty in or at the medical activity of another Department of the Armed Forces affording such in-patient care. This is considered necessary until such time as all medical records, forms, reports, and reporting procedures have been standardized among the three Services, or until all medical department personnel of the several Services who are serving in the numerous medical activities involved have become thoroughly familiar with and effectively indoctrinated as to the remaining differences in the paper work and procedures which must be followed in the case of patients from a sister Service.

(b) Interdepartmental agreement that no interdepartmental reimbursement shall be expected of or made by one Department to another for medical services rendered to military personnel of a sister Service, except for actual hospitalization of personnel of another Service, in which latter case reimbursement should continue to be made at the per diem interdepartmental hospitalization rate which is established annually by the Bureau of the Budget as long as such reimbursement for hospitalization continues to be required between Departments of the Military Establishment.

(c) The assignment of medical personnel — medical department officers, nurses, and enlisted personnel — of one Service for duty in the hospital of a sister Service where such hospital is being utilized

for common or joint hospitalization. Such assignment, for purposes of joint staffing, to be inaugurated and effected on the equitable basis of detailing medical personnel from each Service for duty at each such hospital in approximate proportion to the number of patients from each Service comprising the actual patient-load of that hospital.

(d) To facilitate the administration of such hospitals, the command of and administrative responsibility for hospitals utilized in common for joint hospitalization of patients from two or more of the Departments remains with the owning Department.

22. It is apparent to the Committee that this problem must be kept under continuous review and constant study, since the matter of coordination and integration of the hospitalization programs of the Armed Forces is not a static one. A continuation of central planning of this nature, such as has been done by the Committee in the study which has led to the recommendations contained in this report, is considered to be both necessary and desirable. As time goes on, it will doubtless become possible to recommend still further common or joint utilization of medical facilities of the Armed Forces; similarly, due to constantly changing conditions, it will be found necessary to frequently reconsider, re-evaluate and modify some current recommendations made herein for improving the utilization for hospital and medical facilities. *(See footnote).

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*(Footnote). As an illustration, the effectuation of consolidation under the Department of the Navy of all military sea transport and the associated port facilities of the Army and Navy, announced by the Secretary of Defense as an approved undertaking of the National Military Establishment since the preparation of this study and report, will probably make possible some resultant and concurrent savings in medical facilities associated with any sea transport activities which may be consolidated.

In seeking possible mechanisms which might be recommended as means whereby the foregoing may be accomplished, the Committee rejects as unworkable under the existing structure of the National Military Establishment any concept which would involve the creation of an independent agency or organization for the operation of a single Armed Forces hospital system which would absorb and replace the existing hospital systems of the Armed Forces. The Committee considers, that, with the present three- Department military organization in the National Military Establishment, the best mechanism for effecting continued and increased coordination and integration of the hospitalization policies and hospital programs of the Armed Forces is through the medium of a continuing tri-service Medical Coordinating Board to function at the level of the Office of the Secretary of Defense.

23. Even though it may at a later date be found feasible, after accomplishment of the presently recommended undertakings is reasonably well advanced, to effect still greater common or joint utilization of medical facilities at some individual geographical locations, it is the opinion of the Committee that the general over-all scope of hospitalization and the distribution of hospitals required to provide the Armed Forces with adequate medicall and hospital service cannot at present be further substantially reduced below that recommended in this report without serious effect on the national defense program as a whole. The Committee wishes to strongly emphasize that its recommendations and proposals as contained in this report are predicated primarily upon the impelling necessity of

effecting every feasible economy in the utilization of funds and medical personnel, and especially in view of the shortage in available doctors, dentists, and nurses. This report does not necessarily represent the ideal medical logistic support plan for affording medical and hospital care for the Armed Forces which would be most desirable were the limited availability of medical personnel not such an important factor. In fact, some of the proposals contained in this report are forced by existing necessities and are not representative of sound military logistic doctrine. It must be assumed that in carrying out the will of the nation to provide and support a military establishment of the size deemed necessary by the Congress for national defense, some effective action will be taken by the Congress to insure procurement of the necessary doctors and other medical personnel in the numbers required to maintain and operate at least these minimum medical and hospital services essential to the Armed Forces.

24. It is the opinion of the Committee that it is feasible to improve the utilization of many of the existing Navy dispensary and the Army and Air Force Station Hospital facilities, and to effect some reduction in the total number of medical personnel and funds which would otherwise be required, by reducing wherever practicable the number of individual medical activities at which station hospital type and Navy dispensary level of "in-patient" treatment and care is performed. This can be effected by providing that those patients from two or more separate but nearby military activities who require this type of "in-patient" treatment

and care (i.e., those who can not receive appropriate treatment, care, and observation while continuing on a "duty status"), be consolidated in one of the two or more hospitals or dispensaries which may be readily accessible in the same local vicinity. The following tabulation lists thirty-seven (37) locations in the Continental United States (ZI) where the Committee considers that the treatment and care of station hospital or Navy dispensary type of "in-patients" can now be done in another nearby medical facility:

Naval Receiving Station,
Boston, Massachusetts.

Stewart Field,
Newburgh, New York.

Naval Air Station,
Floyd Bennett Field,
Brooklyn, New York.

Naval Receiving Station,
Brooklyn, New York.

Naval Ammunition Depot,
Earle, New Jersey.

Naval Air Station,
Corpus Christi, Texas.

Naval Air Station,
St. Louis, Missouri.

Station Hospital,
Fort Sheridan, Illinois.

Marine Corps Recruit Depot,
San Diego, California.

Naval Air Station,
San Diego, California.

Naval Air Station,
Lakehurst, New Jersey.

Naval Air Station,
Willow Grove, Pennsylvania.

Naval Supply Depot,
Mechanicsburg, Pennsylvania.

Edgewood Arsenal,
Maryland.

Fort Myer,
Arlington, Virginia.

Andrews Air Force Base,
Washington, D. C.

Marine Corps Station,
Camp Lejeune, New River, N. C.

Marine Corps Recruit Depot,
Parris Island, South Carolina.

Naval Air TTC,
Memphis, Tennessee.

Naval Air Station,
Atlanta, Georgia.

Naval Air Station,
Jacksonville, Florida.

Naval Air Station,
Pensacola, Florida.

Naval Air Station,
New Orleans, Louisiana.

Naval Air Station,
Dallas, Texas.

Naval Receiving Station,
San Diego, California.

Naval Amphibious Base,
Coronado, San Diego, California.

Naval Air Station,
Miramar, San Diego, California.

Naval Auxiliary Air Station,
San Ysidro (Ream Field),
San Diego, California.

Naval Air Station,
Los Alamitos, California.

Navy Dispensary - Marine Corps
Training Center, Oceanside, California.

Naval Air Station,
Santa Ana, California.

Naval Receiving Station,
San Pedro, California.

Naval Auxiliary Air Station,
Monterey, California.

Navy Dispensary,
Treasure Island, California.

Navy Dispensary,
Alameda, California.

Oakland Army Base,
San Francisco, California.

Naval Supply Depot,
Clearfield, Utah.

25. In further exploring practicable means whereby increased economies in personnel and funds can be realized without lowering the ability of the medical departments to efficiently render the required medical support for the Armed Forces, and where further improvement can be effected in the utilization of existing hospital facilities, the Committees has considered how the foregoing may be accomplished with respect to the hospitalization of patients of the "general hospital type." Such patients (i.e., those whose ailments or conditions are such that they require longer periods of observation and definitive treatment or whose disabilities are such as to require highly specialized or complicated treatment to a degree beyond

that available at dispensaries or station hospitals), require evacuation or transfer to an Army General Hospital or to a Naval Hospital which is appropriately staffed and equipped to provide this level of medical attention. The following tabulation lists thirty-three (33) individual posts or stations in the continental United States (ZI) from which such "general hospital type patients" originating thereat may profitably be transferred to a suitable and relatively nearby hospital of another Service, rather than evacuate or transfer such patients to a more distantly located hospital of the same Service:

Fort Jay, Governors Island,
New York, New York.

Fort Hamilton,
Brooklyn, New York.

Mitchell Air Force Base,
Hempstead, Long Island, N. Y.

Fort Totten,
Long Island, New York.

Naval Ammunition Depot,
Earle, New Jersey.

Keesler Air Force Base,
Biloxi, Mississippi.

New Orleans Port of Embarkation,
New Orleans, Louisiana.

Huntsville Arsenal,
Huntsville, Alabama.

Naval Supply Depot,
Mechanicsburg, Pennsylvania.

Fort Eustis,
Virginia.

Fort Monroe,
Virginia.

Langley Air Force Base,
Virginia.

Chatham Air Force Base,
Savannah, Georgia.

Naval Air Station,
Atlanta, Georgia.

MacDill Air Force Base,
Tampa, Florida.

Orlando Air Force Base,
Orlando, Florida.

Eglin Air Force Base,
Florida.

Tyndall Air Force Base,
Panama City, Florida.

Brookley Air Force Base,
Mobile, Alabama.

Craig Air Force Base,
Selma, Alabama.

Maxwell Air Force Base,
Montgomery, Alabama.

Naval Air Station,
Dallas, Texas.

Ellington Air Force Base,
Houston, Texas.

Fort Sheridan,
Illinois.

Branch United States
Disciplinary Barracks (Army),
Milwaukee, Wisconsin.

Naval Air Station
Grosse Isle, Michigan.

Naval Air Station,
Olathe, Kansas.

Naval Ammunition Depot,
Hastings, Nebraska.

March Air Force Base,
Riverside, California.

Fairfield-Suisun Air Force Base,
Fairfield, California.

Oakland Army Base,
Oakland, California.

Fort Lawton,
Seattle, Washington.

Camp Stoneman,
Pittsburg,
California.

26. A more detailed presentation of the salient features summarized in paragraphs 24 and 25 above, relative to improvement in the utilization of medical facilities of the Armed Forces in the continental United States (ZI), is contained later in this report (paragraphs 30 and 31). Some features of the problem of improvement in the utilization of medical facilities in its application to overseas areas differ in complexity and nature from those obtaining in connection with the continental (ZI) medical facilities, and the conclusions of the Committee in connection with overseas areas do not lend themselves to a tabular summarization in the same manner as shown in paragraphs 24 and 25 above in the case of continental medical facilities. A review of the hospital and closely

related medical matters in those extra-continental areas where the Committee believes improvement in the coordination of the medical services and in the utilization of Armed Forces medical facilities are desirable and can be effected, is also contained later in this report (paragraph 32).

27. Having determined the locations where in the opinion of the Committee consolidation of dispensary and station hospital type of "in-patient" treatment and care is deemed practicable, and having determined the places where the Committee believes the hospitalization of "general hospital type patients" originating from posts, camps, and stations can be satisfactorily accomplished by utilizing whatever suitable hospital of the Armed Forces is most conveniently located to the immediate source of such patients, the Committee has next explored the several existing Army General Hospitals and Naval Hospitals with the view to determining which, if any, of such hospitals could advisedly be reduced in status or wholly disestablished and retained in a standby status or disposed of. A review of the latest available information as to the anticipated strengths of the Armed Forces during Fiscal Year 1949 and Fiscal Year 1950, and the planned geographical distribution of these strengths, with the associated estimates as to the number of patients of the Army, Navy, and Air Force for whom hospitalization in Army General Hospitals and in Naval Hospitals will be required, reveal that at this time two (2) such

hospitals can be closed and three other General Hospitals reduced to the status of Station Hospitals, and yet preserve reasonable assurance that there will remain adequate provision of hospitals suitably located to meet the needs of the Armed Forces. The two hospitals of the general hospital type which the Committee believes can advisedly be closed at this time are the U. S.Naval Hospital at Aiea Heights, Pearl Harbor, T. H., and the McCornack General Hospital at Pasadena, California. The 1500 bed normal capacity of the recently completed Tripler General Hospital, Moanalua, T. H., which is located within five (5) miles of the U. S. Naval Hospital, Aiea Heights, Pearl Harbor, T. H., is adequate to accommodate the anticipated total hospital patient-load in the area from all three of the Armed Forces during peacetime. While the constructed capacity of McCornack General Hospital at Pasadena is 742, only about half of this capacity is suitable for general hospital use. The present anticipated peace-time patient-load of NcCornack General Hospital can be adequately accommodated in the U. S. Naval Hospitals at Long Beach and Corona. Moreover, the nature of this hospital (formerly a hotel), and the smallness and precipitous contours of the land area upon which it is situated within the city confines -- too restricted to allow additional emergency construction of any kind -- provides no reserve potential for rapid expansion of its capacity to assist in meeting the urgent needs which will arise for large numbers of additional hospital beds in the event of mobilization of the Armed Forces for national emergency. Such a reserve potential

in this area will be preserved for the Armed Forces by retaining these latter-named hospitals at Corona and Long Beach for joint utilization. The three General Hospitals which the Committee believes can advisedly be reduced to the status of and redesignated as Station Hospitals are: the 183rd General Hospital, Anchorage, Alaska; the Tilton General Hospital, Camp Dix, New Jersey; and the Fort Totten General Hospital, Fort Totten, Long Island, New York. The hospitalization of general hospital type patients now provided in Tilton General Hospital can be accomplished at the Valley Forge General Hospital, Phoenixville, Pennsylvania, the U. S. Naval Hospital, Philadelphia, Pennsylvania, and the U. S.Naval Hospital, St. Albans, New York. The hospitalization of general hospital type patients from Fort Totten, Long Island, New York, can be provided in the U. S. Naval Hospital, St. Albans, New York.

28. The following recommendations of the Committee are submitted relative to "Programs for Hospitalization in the Armed Forces and for Improvement in Utilization of Existing Hospital Facilities." These recommendations, which are unanimously recommended for early approval, fall into two groups or categories: First, recommendations bearing on the general problem and second, recommendations pertaining more specifically to individual geographic localities and/or particular medical installations. It is to be emphasized that the feasibility of successful implementation of many of the specific recommendations in the second category is largely dependent upon approval and

implementation of recommendations contained in the first category. The recommendations contained in the second category, i.e., with reference to improvement in utilization of Armed Forces hospitals and similar medical facilities at specifically named geographic localities, are confined to those where change in present status or functions of specific installations with reference to hospitalization appears to be feasible. Hospitals and dispensaries not mentioned in these specific recommendations are considered necessary for continuation in their present status, or as may be determined by the individual Service concerned. These recommendations in the second category are further divided into two groups: Continental United States (Zone of Interior), and Extra-Continental (Overseas).

R E C O M M E N D A T I O N S

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RECOMMENDATIONS OF A GENERAL NATURE

29. It is recommended that:

(1) In the earnest desire and zealous effort to effect greater economy, the programs for hospitalization in the Armed Forces not be so divorced from fundamental military considerations as to abnegate or abrogate the basic principles which have proven sound in the crucible of time and long experience.

(2) In consonance with the above recommendation, the programs for hospitalization in the Armed Forces be of such a nature at all times as will insure:

(a) That the present standard of hospital treatment and medical care now afforded all personnel of the Armed Forces is maintained.

(b) That full medical support, including hospitalization, will be readily available and reasonably accessible for each and every military unit of the Armed Forces.

(c) That these programs for hospitalization in the Armed Forces be ever such as will contribute to and assist in the accomplishment of the primary purposes and missions of the medical departments

of the Armed Forces as enumerated in paragraph 3, page 3 of this report.

(d) That the organization, administration and operation of the hospital programs and services of the Armed Forces are in conformity with and workable under the existing organizational structure of the National Military Establishment.

(e) That the most efficient utilization is made of the limited supply of medical personnel.

(f) That they contribute to the greatest possible conservation of manpower and funds for the Armed Forces as a whole, through minimizing patient transportation costs and by reducing the average time during which patients are absent from their normal military assignments by reason of being on the sick list.

(g) That a minimum reserve capacity be retained in the Armed Forces' hospitals (represented by the excess of constructed bed capacities over present capacities now being used in existing hospitals as "authorized operating capacities") sufficient to meet the initial increased hospitalization requirements which will arise as an immediate necessity should sudden armed conflict, rapid expansion of the Armed Forces, or military mobilization occur.

(3) Provision continue to be made in hospitals of the Armed Forces for all military patients requiring hospitalization.

(4) Civilian and non-military hospitals continue to be utilized in those instances of an emergency nature where members of the military forces become ill or injured while on leave, in transit, or are on detached, independent, or isolated duty at a location where no military hospital is readily available, and in those exceptional cases when, by reason of the very special or unusual nature of the patient's disease or condition, suitable treatment and care can be more appropriately provided in s ome selected non-military medical facility.

(5) That the full responsibility for providing all hospitalization and medical care for all Services in certain specialized fields of medicine not be allocated exclusively to any one Service, but that jointly staffed Specialized Diagnostic and Treatment Centers for patients in certain special fields of medicine from all three Services be designated or established in connection with and as a part of selected Army General Hospitals and U. S. Naval Hospitals as may from time to time be feasible and appropriate.

(6) In consonance with the foregoing recommendation and as the initial undertaking of that nature, the U. S. Naval Hospital, Houston, Texas, in addition to its continued use as a hospital for general medical and surgical patients, be designated as a Specialized Diagnostic and Treatment Center for Psychotic and Neuropsychiatric Patients from all three of the Armed Forces, such Center to be jointly staffed by

medical department personnel from each Service in relative proportion to the number of such patients being treated therein from each Service. *(See footnote)

(7) Wherever and whenever medical facilities are utilized jointly or in common for regularly providing medical services and hospitalization (in-patient treatment and care) for personnel from two or more of the Armed Forces, the following be agreed upon and confirmed by the three Departments:

(a) That appropriate medical department liaison and clerical personnel be detailed from the Department or command whose patients are being provided treatment and care in or by the medical facility of another Department, for duty in or at such medical activity of the other Service.

(b) That no interdepartmental reimbursement or transfer of funds shall be expected of or made by one Department or Service to another for medical attention rendered to personnel of another Service, except for actual hospitalization (in-patient treatment and care) of Military personnel of another Service,

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*(Footnote). Subsequent to the Committee's study of this problem and its unanimous agreement on the recommendations relative to the Armed Forces' common utilization of the U. S. Naval Hospital, Houston, Texas, the President has by Executive Order directed that this hospital be transferred to the Veterans Administration for the latter's ownership, use, and operation.

in which latter case interdepartmental reimbursement shall continue to be made at the per diem interdepartmental hospitalization rate which is established annually by the Bureau of the Budget as long as the present requirement exists for such reimbursement to be made between Departments of the Military Establishment.

(c) That, for purposes of joint staffing, medical department personnel - officers, nurses and enlisted - of one Service will be assigned to and detailed for duty in the hospital of a sister Service where such hospital is being regularly utilized for common or joint hospitalization. Such assignment shall be inaugurated and effected on the equitable basis of assigning and detailing medical department personnel of each Service to each such jointly utilized hospital in the same approximate proportion as the number of patients in that hospital from each Service bears to the total combined patient-load in that hospital.

(d) That command of and Departmental administrative responsibility for hospitals utilized in common for joint hospitalization of patients from two or more of the Armed Forces shall remain with the owning Department or Service.

(8) As a general policy of the National Military Establishment, to be followed wherever practical considerations permit adherence to such a policy, individual hospitals of the Armed Forces for treatment and care of general medical and surgical patients not be operated, or permanently constructed for such operation, at a normal capacity exceeding 1500 beds; and further, that 1000 beds be accepted as the optimum normal bed-capacity of such hospitals in so far as may be practicable in meeting the needs of the Armed Forces.

(9) That the plans for future construction of any new hospital facilities in any Department of the Armed Forces be fully coordinated among the three Departments to insure that, in accordance with the objectives, principles and limitations indicated in this report, any such newly planned hospital will be of such size and location as will best serve the combined hospitalization needs of all three Armed Forces.

(10) Army General Hospitals of a permanent nature located in territories or possessions of the United States be designated as and placed in the category of Army Class II installations under the command and control of the Surgeon General of the Army in a similar manner and to the same extent as now obtains in the case of Army General Hospitals in the continental United States (Zone of Interior).

(11) Wherever station hospitals and/or dispensaries are operated at or primarily in connection with Army, Navy, or Air Force posts, camps, stations or bases and for the principal purpose of providing station hospital type or dispensary level of medical services and

hospitalization (in-patient treatment and care) for a particular post, camp, station or base, that such station hospitals and/or dispensaries be operated and administered as activities of the same Service and of the same administrative command as that of the particular post, camp, station or base where they are located and for whose medical support they predominantly function.

(12) Within the limitations of existing physical facilities and where administratively and operationally feasible, and where not precluded by other governing considerations, hospitalization (in-patient treatment and care) of patients from two or more separate but nearby military activities or installations, and of whatever Service, be consolidated in one of the two or more hospitals or dispensaries of the Armed Forces which are readily accessible in the same local vicinity.

(13) Where evacuation or transfer of patients to another locality is necessary or indicated for appropriate hospitalization (in-patient treatment and care) at a more suitably staffed and more specially equipped General or Naval Hospital, the evacuation or transfer of such patients be made to a suitable hospital of another of the Armed Forces if such hospital has facilities available to accommodate these patients and if it is more readily accessible than a much more distantly located hospital of the same Service from which the patients originate.

(14) A continuing study be conducted for the purpose of developing and attaining the highest practicable degree of uniformity in the organization, administration and operation of all hospitals of the Armed Forces.

(15) The greater standardization of medical forms and reporting procedures among the three Services be expedited in order to lessen the administrative difficulties attending joint hospitalization and to simplify the problems involved in common utilization of medical facilities.

(16) In order to continue central planning in the field of this report, and to insure that constant study and the necessary continuous review of the problem is maintained, a continuing interdepartmental Committee on Programs for Hospitalization and Utilization of Hospital Facilities in the Armed Forces be formed; that such a Committee be composed of three members, to consist of one representative each from the Offices of the Surgeon General of the Army, the Surgeon General of the Navy and the Air Surgeon, with the member senior in grade also acting as chairman; and that such Committee work under the direction of and be responsible to the Surgeons General and the Air Surgeon acting conjointly at the level of the Office of the Secretary of Defense.

RECOMMENDATIONS REGARDING INSTALLATIONS AT SPECIFIC LOCALITIES OR AREAS

CONTINENTAL UNITED STATES (ZONE OF INTERIOR)

30. It is recommended that:

(1) The Navy dispensary at the Naval Receiving Station, Boston, Massachusetts, be reduced in function to correspond to that of an Army type dispensary, and that all hospitalization (in-patient treatment and care) of patients from this activity be performed in the Chelsea Naval Hospital, Chelsea (Boston), Massachusetts.

(2) The Station Hospital, Stewart Field, Newburgh, New York, be reduced in function to that of an Army type dispensary and that hospitalization (in-patient treatment and care) of station hospital type patients from this activity be provided at the Station Hospital, U. S. Military Academy, West Point, New York.

(3) The Navy dispensary at the Naval Air Station, Floyd Bennett Field, Brooklyn, New York, be reduced in function to correspond to that of an Army type dispensary, and that all hospitalization (in-patient treatment and care) of patients from this activity be performed at the U. S. Naval Hospital, St. Albans, New York.

(4) The Navy dispensary at the Naval Receiving Station, Brooklyn, New York, be reduced in function to correspond to that of an Army type dispensary, and that all hospitalization (in-patient treatment and care) of patients from this activity be performed in the U. S. Naval Hospital, St. Albans, Long Island, New York.

(5) The Navy dispensary at the Naval Ammunition Depot, Earle, New Jersey, be reduced in function to correspond to that of an Army type dispensary, and that hospitalization (in-patient treatment and care) of station hospital type patients from this activity be accomplished in the Station Hospital (Army) at Fort Monmouth, New Jersey.

(6) The Navy dispensary at the Naval Air Station, Lakehurst, New Jersey, be reduced in function to correspond to that of an Army type dispensary, and that hospitalization (in-patient treatment and care) of station hospital type patients from this activity be accomplished in the Tilton General Hospital (recommended in subparagraph 43 below to be reduced to the status of and redesignated as a Station Hospital), Fort Dix, New Jersey.

(7) The Navy dispensary at the Naval Air Station, Willow Grove, Pennsylvania, be reduced in function to correspond to that of an Army type dispensary, and that all hospitalization (in-patient treatment and care) of patients from this activity be provided in the U. S. Naval Hospital, Philadelphia, Pennsylvania.

(8) The Navy dispensary at the Naval Supply Depot, Mechanicsburg, Pennsylvania, be reduced in function to correspond to that of an Army type dispensary, and that hospitalization (in-patient treatment and care) of station hospital type patients from this activity be provided in the Station Hospital (Army), Carlisle Barracks, Pennsylvania.

(9) The Station Hospital at Edgewood Arsenal, Maryland, be reduced in function to that of an Army type dispensary, and that the

hospitalization (in-patient treatment and care) of station hospital type patients from this activity be performed in the Station Hospital, Aberdeen Proving Ground, Aberdeen, Maryland.

(10) The Navy dispensary at the Naval Station, Bainbridge, Maryland, be reduced in function to correspond to that of an Army type dispensary, and that hospitalization (in-patient treatment and care) of station hospital type patients from this activity be accomplished in the Station Hospital (Army), Aberdeen, Maryland.

(11) The Station Hospital, Fort Myer, Arlington, Virginia, be reduced in function to that of an Army type dispensary, and that hospitalization (in-patient t reatment and care) of station hospital type patients from this activity be accomplished in the Station Hospital (Army), Fort Belvoir, Virginia.

(12) The dispensary at the Marine Corps Station, Camp Lejeune, New River, North Carolina, be reduced in function to correspond to that of an Army type dispensary, and that all hospitalization (in-patient treatment and care) of patients from this activity be accomplished in the U. S. Naval Hospital, Camp Lejeune, New River, North Carolina.

(13) The dispensary at Marine Corps Recruit Depot, Parris Island, South Carolina, be reduced in function to correspond to that of an Army type dispensary, and that all hospitalization (in-patient treatment and care) of patients from this activity be in the U. S. Naval Hospital, Parris Island (Beaufort), South Carolina.

(14) The Navy dispensary at the Naval Air Technical Training Command, Memphis, Tennessee, be reduced in function to correspond to that of an Army type dispensary, and that all hospitalization (in-patient treatment and care) of patients from this activity be accomplished in the U. S. Naval Hospital, Memphis, Tennessee.

(15) The Navy dispensary at the Naval Air Station, Atlanta, Georgia, be reduced in function to correspond to that of an Army type dispensary and that hospitalization (in-patient treatment and care) of station hospital type patients from this activity be accomplished in the Station Hospital (Army) at Fort McPherson, Georgia.

(16) The Navy dispensary at the Naval Air Station, Jacksonville, Florida, be reduced in function to correspond to that of an Army type dispensary, and that all hospitalization (in-patient treatment and care) of patients from this activity be performed in the U. S. Naval Hospital, Jacksonville, Florida.

(17) The Navy dispensary at the Naval Air Station, Pensacola, Florida, be reduced in function to correspond to that of an Army type dispensary, and that all hospitalization (in-patient treatment and care) of patients from this activity be performed in the U. S. Naval Hospital, Pensacola, Florida.

(18) The Navy dispensary at the Naval Air Station, New Orleans, Louisiana, be reduced in function to correspond to that of an Army type dispensary and that hospitalization (in-patient treatment and care) of station hospital type patients from this activity be accomplished in the Station Hospital (Army), New Orleans Port of

Embarkation, New Orleans, Louisiana.

(19) The Navy dispensary at the Naval Air Station, Dallas, Texas, be reduced in function to correspond to that of an Army type dispensary, and that hospitalization (in-patient treatment and care) of station hospital type patients from this activity be accomplished in the Station Hospital (Air Force), Carswell Air Force Base, Fort Worth, Texas.

(20) The Navy dispensary at the Naval Air Station, Corpus Christi, Texas, be reduced in function to correspond to that of an Army type dispensary, and that all hospitalization (in-patient treatment and care) of patients from this activity be accomplished in the U. S. Naval Hospital, Corpus Christi, Texas.

(21) The Navy dispensary at the Naval Air Station, St. Louis, Missouri, be reduced in function to correspond to that of an Army type dispensary and that hospitalization (in-patient treatment and care) of station hospital type patients from this activity be accomplished in the Station Hospital (Air Force), Scott Air Force Base, Illinois.

(22) The Station Hospital at Fort Sheridan, Illinois, be reduced in function to that of an Army type dispensary, and that all hospitalization (in-patient treatment and care) of patients from this activity be accomplished in the U. S. Naval Hospital, Great Lakes, Illinois.

(23) The dispensary at the Marine Corps Recruit Depot, San Diego, California, be reduced in function to correspond to that of an Army type dispensary, and that all hospitalization (in-patient treatment

and care) of patients from this activity be accomplished in the U. S. Naval Hospital, San Diego, California.

(24) The Navy dispensary, U. S. Naval Air Station, San Diego, California, be reduced in function to correspond to that of an Army type dispensary, and that all hospitalization (in-patient treatment and care) of patients from this activity be accomplished in the U. S. Naval Hospital, San Diego, California.

(25) The Navy dispensary, U. S. Naval Receiving Station, San Diego, California, be reduced in function to correspond to that of an Army type dispensary, and that all hospitalization (in-patient treatment and care) of patients from this activity be accomplished in the U. S.Naval Hospital, San Diego, California.

(26) The Navy dispensary, Naval Amphibious Base, Coronado, California, be reduced in function to correspond to that of an Army type dispensary, and that all hospitalization (in-patient treatment and care) of patients from this activity be accomplished in the U. S. Naval Hospital, San Diego, California.

(27) The Navy dispensary, Naval Air Station, Miramar, San Diego, California, be reduced in function to correspond to that of an Army type dispensary, and that all hospitalization (in-patient treatment and care) of patients from this activity be accomplished in the U. S. Naval Hospital, San Diego, California.

(28) The Navy dispensary at the Naval Auxiliary Air Station, San Ysidro (Ream Field), San Diego, California, be reduced in function

to correspond to that of an Army type dispensary, and that all hospitalization (in-patient treatment and care) of patients from this activity be accomplished in the U. S. Naval Hospital, San Diego, California.

(29) The dispensary at the Marine Corps Training Center, Oceanside, California, be reduced in function to correspond to that of an Army type dispensary, and that all hospitalization (in-patient treatment and care) of patients from this activity be in the U. S. Naval Hospital, Santa Margarita Ranch, Oceanside, California.

(30) The Navy dispensary at the Naval Air Station, Los Alamitos, California, be reduced in function to correspond to that of an Army type dispensary, and that all hospitalization (in-patient treatment and care) of patients from this activity be accomplished in the U. S. Naval Hospital, Long Beach, California.

(31) The Navy dispensary at the Naval Air Station, Santa Ana, California, be reduced in function to correspond to that of an Army type dispensary, and that all hospitalization (in-patient treatment and care) of patients from this activity be accomplished in the U. S. Naval Hospital, Long Beach, California.

(32) The Navy dispensary at the Naval Receiving Station, San Pedro, California, be reduced in function to correspond to that of an Army type dispensary and that all hospitalization (in-patient treatment and care) of patients from this activity be accomplished in the U. S. Naval Hospital, Long Beach, California.

(33) The Navy dispensary, Naval Auxilliary Air Station, Monterey, California, be reduced in function to correspond to that of an Army type dispensary and that hospitalization (in-patient treatment and care) of station hospital type patients from this activity be accomplished in the Station Hospital (Army), Fort Ord, California.

(34) The Navy dispensary, Treasure Island, California, be reduced in function to correspond to that of an Army type dispensary, and that all hospitalization (in-patient treatment and care) of patients from this activity be accomplished in the U. S. Naval Hospital, Oakland, California.

(35) The Navy dispensary at Alameda, California, be reduced in function to correspond to that of an Army type dispensary, and that hospitalization (in-patient treatment and care) of patients from this activity be accomplished in the U. S. Naval Hospital, Oakland, California.

(36) The Station Hospital at Oakland Army Base, San Francisco, California, be reduced in function to that of an Army type dispensary, and that all hospitalization (in-patient treatment and care) of patients from this activity be accomplished in the U. S. Naval Hospital, Oakland, California.

(37) The Navy dispensary at the Naval Supply Depot, Clearfield, Utah, be reduced in function to correspond to that of an Army type dispensary and that hospitalization (in-patient treatment and care) of station hospital type patients from this activity be accomplished in the Station Hospital (Air Force), Hill Air Force Base, Ogden, Utah.

(38) Hospitalization of general hospital type patients from the Station Hospital at Fort Jay, Governors Island, New York, be accomplished at the U. S. Naval Hospital, St. Albans, Long Island, New York.

(39) Hospitalization of general hospital type patients from the Station Hospital at Fort Hamilton, Brooklyn, New York, be accomplished in the U. S.Naval Hospital, St. Albans, Long Island, New York.

(40) Hospitalization of general hospital type patients from the Station Hospital, Mitchell Air Force Base, New York, be accomplished at the U. S. Naval Hospital, St. Albans, Long Island, New York.

(41) The Fort Totten General Hospital at the Army Medical Center, Fort Totten, Long Island, New York, be redesignated as a Station Hospital in connection with the Army Medical Center at that place, and that the hospitalization of general hospital type patients originating from the Fort Totten activities be accomplished in the U. S. Naval Hospital, St. Albans, Long Island, New York.

(42) Hospitalization of general hospital type patients from the Naval Supply Depot, Mechanicsburg, Pennsylvania, be accomplished in the Valley Forge General Hospital, Phoenixville, Pennsylvania.

(43) The Tilton General Hospital, Camp Dix, New Jersey, be reduced to the status of and redesignated as a Station Hospital, and that the hospitalization of general hospital type patients now

provided at this hospital be accomplished at the Valley Forge General Hospital, Phoenixville, Pennsylvania, the U. S. Naval Hospital, Philadelphia, Pennsylvania, and the U. S. Naval Hospital, St. Albans, New York.

(44) Hospitalization of general hospital type patients from the Station Hospital, Fort Eustis, Virginia, be accomplished in the U. S.Naval Hospital, Portsmouth, Virginia.

(45) Hospitalization of general hospital type patients from the Station Hospital, Fort Monroe, Virginia, be accomplished in the U. S. Naval Hospital, Portsmouth, Virginia.

(46) Hospitalization of general hospital type patients from the Station Hospital, Langley Air Force Base, Virginia, be accomplished in the U. S. Naval Hospital, Portsmouth, Virginia.

(47) Hospitalization of general hospital type patients from the Station Hospital, Chatham Air Force Base, Savannah, Georgia, be accomplished in the U.S.Naval Hospital, Parris Island (Beaufort), South C$_a$rolina.

(48) Hospitalization of general hospital type patients from the Navy dispensary, Naval Air Station, Atlanta, Georgia, be accomplished in the Oliver General Hospital, Augusta, Georgia.

(49) Hospitalization of general hospital type patients from the Station Hospital, McDill Air Force Base, Tampa, Florida, be accomplished in the U. S. Naval Hospital, Jacksonville, Florida.

(50) Hospitalization of general hospital type patients from the Station Hospital, Orlando Air Force Base, Orlando, Florida, be accomplished in the U. S. Naval Hospital, Jacksonville, Florida.

(51) Hospitalization of general hospital type patients from the Station Hospital, Eglin Air Force Base, Florida, be accomplished in the U. S. Naval Hospital, Pensacola, Florida.

(52) Hospitalization of general hospital type patients from the Station Hospital, Tyndall Air Force Base, Panama City, Florida, be accomplished in the U. S. Naval Hospital, Pensacola, Florida.

(53) Hospitalization of general hospital type patients from the Station Hospital, Brookley Air Force Base, Mobile, Alabama, be accomplished in the U. S. Naval Hospital, Pensacola, Florida.

(54) Hospitalization of general hospital type patients from the Station Hospital, Craig Air Force Base, Selma, Alabama, be accomplished in the U. S. Naval Hospital, Pensacola, Florida.

(55) Hospitalization of general hospital type patients from the Station Hospital, Maxwell Air Force Base, Montgomery, Alabama, be accomplished in the U. S. Naval Hospital, Pensacola, Florida.

(56) Hospitalization of general hospital type patients from the Station Hospital, Keesler Air Force Base, Biloxi, Mississippi, be accomplished in the U. S. Naval Hospital, Pensacola, Florida.

(57) Hospitalization of general hospital type patients from the Station Hospital, New Orleans Port of Embarkation, New Orleans, Louisiana, be accomplished in the U. S. Naval Hospital, Pensacola, Florida.

(58) Hospitalization of general hospital type patients from the Station Hospital, Huntsville Arsenal, Huntsville, Alabama, be accomplished in the U. S. Naval Hospital, Memphis, Tennessee.

(59) Hospitalization of general hospital type patients from the Navy dispensary, Naval Air Station, Dallas, Texas, be accomplished at Brooke General Hospital, San Antonio, Texas.

(60) Hospitalization of general hospital type patients from the Ellington Air Force Base, Houston, Texas, be accomplished in the U. S.Naval Hospital, Houston, Texas (See footnote at bottom of page 40).

(61) Hospitalization of general hospital type patients from the Station Hospital, Branch U. S. Disciplinary Barracks, (Army) Milwaukee, Wisconsin, be accomplished in the U. S. Naval Hospital, Great Lakes, Illinois.

(62) Hospitalization of general hospital type patients from the Naval Air Station, Grosse Isle, Michigan, be accomplished in the Percy Jones General Hospital, Battle Creek, Michigan.

(63) Hospitalization of general hospital type patients from the Navy dispensary, Naval Air Station, Olathe, Kansas, be accomplished in the Fitzsimons General Hospital, Denver, Colorado.

(64) Hospitalization of general hospital type patients from the Navy dispensary, Naval Ammunition Depot, Hastings, Nebraska, be accomplished in the Fitzsimons General Hospital, Denver, Colorado.

(65) Hospitalization of general hospital type patients from the Naval Supply Depot, Clearfield, Utah, be accomplished at the Fitzsimons General Hospital, Denver, Colorado.

(66) The McCornack General Hospital, Pasadena, California, be closed and that the hospitalization (in-patient treatment and care) now being provided by this hospital be accomplished at the U. S. Naval Hospitals, Corona and the U. S. Naval Hospital, Long Beach, California.

(67) Hospitalization of general hospital type patients from the Station Hospital, March Air Force Base, Riverside, California, be accomplished at the U. S. Naval Hospital, Corona, California.

(68) Hospitalization of general hospital type patients from the Station Hospital, Fairfield-Suisun Air Force Base, Fairfield, California, be accomplished at the U. S. Naval Hospital, Mare Island, California.

(69) Hospitalization of general hospital type patients from the Station Hospital, Camp Stoneman, Pittsburg, California, be accomplished at the U. S. Naval Hospital, Mare Island, California.

(70) Hospitalization of general hospital type patients from the Station Hospital, Oakland Army Base, Oakland, California, be accomplished at the U. S. Naval Hospital, Oakland, California.

(71) Hospitalization of general hospital type patients from the Station Hospital, Fort Lawton, Seattle, Washington, be accomplished at the U. S. Naval Hospital, Bremerton, Washington.

31. It is recommended that the following listed Army General Hospitals and U. S. Naval Hospitals in the Continental United States (Zone of Interior) be continued in active operation and, taking into consideration the recommendations contained in paragraphs 29 and 30 above, that they be utilized and operated at such authorized capacities as may be required to suitably provide for the requirements of the three Armed Forces for such hospitalization:

(1) U. S. Naval Hospital, Chelsea (Boston), Mass.

(2) Murphy General Hospital, Waltham, Mass.

(3) U. S. Naval Hospital, Portsmouth, N. H.

(4) U. S. Naval Hospital, Newport, R. I.

(5) St. Albans Naval Hospital, Long Island (New York), N. Y.

(6) U. S. Naval Hospital, Philadelphia, Pa.

(7) Valley Forge General Hospital, Phoenixville, Pa.

(8) U. S. Naval Hospital, Annapolis, Md.

(9) U. S. Naval Hospital, Quantico, Va.

(10) U. S. Naval Hospital, National Naval Medical Center, Bethesda, Md.

(11) Walter Reed General Hospital, Army Medical Center, Washington, D. C.

(12) U. S. Naval Hospital, Portsmouth, Va.

(13) U. S. Naval Hospital, Camp Lejeune, N. C.

(14) U. S. Naval Hospital, Charleston, S. C.

(15) U. S. Naval Hospital, Parris Island (Beaufort), S. C.

(16) U. S. Naval Hospital, Jacksonville, Fla.

(17) U. S. Naval Hospital, Pensacola, Fla.

(18) U. S. Naval Hospital, Key West, Fla.

(19) Oliver General Hospital, Augusta, Ga.

(20) U. S. Naval Hospital, Memphis, Tenn.

*(21) U. S. Naval Hospital, Houston, Texas.

(22) Brooke General Hospital, Fort Sam Houston, San Antonio, Texas.

(23) U. S. Naval Hospital, Corpus Christi, Texas.

(24) Beaumont General Hospital, El Paso, Texas

(25) Army and Navy General Hospital, Hot Springs, Arkansas.

(26) U. S. Naval Hospital, Great Lakes, Illinois.

(27) Percy Jones General Hospital, Battle Creek, Michigan.

(28) Fitzsimons General Hospital, Denver, Colorado.

(29) U. S. Naval Hospital, San Diego, California

(30) U. S. Naval Hospital, Santa Margarita Ranch, Oceanside, California.

(31) U. S. Naval Hospital, Long Beach, California.

(32) U. S. Naval Hospital, Corona, California.

(33) Letterman General Hospital, Presidio of San Francisco, California.

(34) U. S. Naval Hospital, Mare Island, California.

(35) U. S. Naval Hospital, Oakland, California.

(36) Madigan General Hospital, Fort Lewis, Washington.

(37) U. S. Naval Hospital, Bremerton, Washington.

In connection with the above list of Army General Hospitals and U. S. Naval Hospitals, the Committee wishes to point out that several of the hospitals classified and listed above as Army General Hospitals also function as station hospitals for the nearby military commands, in addition to their General Hospital functions; further that several of the hospitals classified and listed above as U. S. Naval Hospitals are not comparable to Army General Hospitals, in that they perform only those functions and levels of medical and hospital care which are comparable to that of a station hospital.

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* See footnote at bottom of page 40 relative to the U. S. Naval Hospital, Houston, Texas.

EXTRA-CONTINENTAL (OVERSEAS)

32. A.-PANAMA CANAL ZONE AREA

It is recommended that:

(1) The designation of the hospital at Fort Gulick as a station hospital be discontinued and that this medical facility be reduced in status and function to that of an Army type dispensary.

(2) All Armed Forces hospitalization (in-patient treatment and care) of Armed Forces personnel located on the Atlantic Side of the Isthmus of Panama be accomplished in the U. S. Naval Hospital, Coco, Solo, C. Z.

(3) All Armed Forces hospitalization (in-patient treatment and care) of Armed Forces personnel located on the Pacific side of the Isthmus of Panama be accomplished in the Fort Clayton Station Hospital (Army).

(4) Gorgas Hospital (operated by the Panama Canal Administration) be utilized, within the means available at that hospital, by the military services to provide specialized consultation, diagnostic procedures, treatment or hospitalization as may be requested by the military services

for selected patients requiring such highly specialized service and/or treatment at or from medical activities of the Armed Forces in the area.

(5) There be established a continuing Area Joint Medical Advisory Committee to be composed of four members and consisting of the senior medical officer on duty in that area with each of the three Armed Forces and the Chief Health Officer of the Panama Canal, for the purpose of supervising the coordinated utilization of all medical activities, including hospitalization, within the area; and, to continuously effect coordination of local medical plans appropriate for use in event of disaster or other serious emergency. Further, that the medical officer who is senior in grade on this Area Joint Medical Advisory Committee serve as its Chairman, and that, as the representative of that Committee, he act as the principal medical advisory or medical director on the staff of the Commander-in-Chief, Caribbean Command.

NOTE: As a result of the Committee's interim report of 18 May 1948 on the Panama Canal Zone area, the above recommendations relative to hospitalization in the Panama Canal Zone area have already been approved in substance by the Secretary of Defense (on 7 June 1948), and either have been or are now being implemented by Departmental action.

B.-TRINIDAD, B. W. I.

It is recommended that:

(1) The 359th Station Hospital (Army), at Waller Air Force Base be inactivated for the purpose of establishing an Air Force station hospital at that base. (The troop spaces involved have already been transferred to the Air Force by JAAFAR 1-11-50 of 5 November 1948.)

(2) An Air Force station hospital be established at Waller Air Force Base concurrently with the inactivation of the 359th Station Hospital at that place.

(3) The Air Force dispensary at Waller Air Force base be closed and that both out-patient and in-patient medical care at that Base be rendered by the Air Force station hospital when established as recommended in (1) and (2) above.

C.-PUERTO RICO

It is recommended that:

(1) All hospitalization (in-patient treatment and care) of patients from all Army, Navy, and Air Force activities located in the immediate vicinity of the city of San Juan be accomplished in Rodriquez General Hospital, San Juan, P. R.

(2) The Navy dispensary at the Naval Air Station, San Juan, P. R., be reduced in function to correspond to that of an Army type dispensary, and that all hospitalization (in-patient treatment and care) of patients from this activity be provided in Rodriquez General Hospital as recommended in (1) above.

(3) The 330th Station Hospital (Army) located at Ramey Field be inactivated for the purpose of establishing an Air Force station hospital at that installation.

(4) An Air Force station hospital be established at Ramey Field concurrently with the inactivation of the 330th Station Hospital at that place. (The troop spaces involved have already been transferred to the Air Force by JAAFAR 1-11-50 of 5 November 1948.)

(5) The Air Force dispensary at Ramey Field be discontinued as an entity separate from the Station Hospital, and that both in-patient and out-patient medical care at that station be provided by the Air Force station hospital when established as recommended in (3) and (4) above.

(6) If and when construction of a new hospital building is undertaken for Rodriquez General Hospital, San Juan, P. R., the planning for and construction of

such new hospital be on the basis of its common utilization by all the Armed Forces and to meet the combined needs of the three Services for such hospitalization in that locality.

(7) Plans for construction of a new building for Rodriquez General Hospital be considered a project of low priority at this time, and that development of such plans in accordance with paragraph (6) above be deferred until figures as to future deployment of forces and troop strengths in that area are determined by and become available from the Joint Chiefs of Staff for such long-range construction planning purposes.

D.-CUBA

It is recommended that:

(1) The Navy dispensary located contiguous to the U. S. Naval Hospital, Naval Operating Base, Guantanamo Bay, Cuba, be discontinued as a separate entity and that the dispensary be consolidated and incorporated in the Naval Hospital.

NOTE: This consolidation has already been effected by recent Naval administrative action.

(2) The present hospital building, which is of rambling wooden construction, now housing the U. S. Naval Hospital, Naval Operating Base, Guantanamo Bay, Cuba, be replaced as early as possible by a new building of permanent and more fire-resistant construction.

E.-BERMUDA

It is recommended that:

(1) The present disintegrating hospital building, which has been condemned as unsafe, at the Bermuda Air Base Command, Kindley Field, Bermuda, be replaced as early as possible by a smaller new building of permanent or semi-permanent construction to suitably accommodate the Air Force station hospital at that place.

F.-GERMANY

It is recommended that:

(1) The 317th Station Hospital (Army), Wiesbaden Air Force Base, Germany, be inactivated for the purpose of establishing an Air Force station hospital at that base. (The troop spaces involved have already been transferred to the Air Force by JAAFAR 1-11-50 of 5 November 1948.)

(2) An Air Force station hospital be established at Wiesbaden Air Force Base, Germany, concurrently with the inactivation of the 317th Station Hospital at that place.

G.-HAWAII

It is recommended that:

(1) All hospitalization for all the Armed Forces on Oahu, T. H., be accomplished in the new Tripler General Hospital, Oahu, T. H.

(2) Tripler General Hospital be designated as and placed in the category of a Class II installation of the Army and under the command and control of the Surgeon General of the Army in the same manner and to the same extent as are General Hospitals which are located in the Continental United States (Zone of Interior).

(3) The U. S. Naval Hospital, Aiea Heights, Pearl Harbor, T. H., be disestablished and retained in a maintenance status to meet possible future Armed Forces hospitalization needs in that area, and that all hospitalization now being provided in this hospital be accomplished in the Tripler General Hospital as recommended in (1) above.

(4) When the U. S. Naval Hospital, Aiea Heights, Pearl Harbor, T. H., is disestablished and placed in a maintenance status, the officers', nurses' and medical enlisted personnel's quarters at the U. S. Naval Hospital, Aeia Heights, continue to be utilized and occupied by Navy medical department personnel who will be assigned for duty at Tripler General Hospital in accordance with the principle and policy of joint personnel staffing of hospitals when so utilized in common by two or more of the Armed Forces.

(5) The 26th Station Hospital (Army), Schofield Barracks, Oahu, T. H., be reduced in function to that of an Army type dispensary, and that all hospitalization (in-patient treatment and care) of patients from this activity be accomplished in the Tripler General Hospital.

(6) The station hospital at Hickham Air Force Base, Pearl Harbor, Oahu, T. H., be reduced in function to that of an Army type dispensary, and that all hospitalization (in-patient treatment and care) of patients from this activity be accomplished in Tripler General Hospital.

(7) The Navy dispensary, Naval Air Station, Pearl Harbor, T. H., be reduced in function to correspond to that of an Army type dispensary, and that all hospitalization (in-patient treatment and care) of patients from this activity be accomplished in Tripler General Hospital.

(8) The Navy dispensary, Naval Air Station, Keehi Lagoon, Oahu, T. H., be reduced in function to correspond to that of an Army type dispensary and that all hospitalization (in-patient treatment and care) of patients from this activity be accomplished in Tripler General Hospital.

(9) The Navy dispensary, Naval Ammunition Depot, Lualualei, Oahu, T. H., be reduced in function to correspond to that of an Army type dispensary, and that all hospitalization (in-patient treatment and care) of patients from this activity be accomplished in Tripler General Hospital.

(10) The Navy dispensary, Naval Air Station, Barbers Point, Oahu, T. H., be reduced in function to correspond to that of an Army type dispensary and that all hospitalization (in-patient treatment and care) of patients from this activity be accomplished in Tripler General Hospital.

(11) The Navy dispensary, Naval Air Station, Kaneohe Bay, Oahu, T. H., be reduced in function to correspond to that of an Army type dispensary and that all hospitalization (in-patient treatment and care) of patients from this activity be accomplished in Tripler General Hospital.

H.-KWAJALEIN

It is recommended that:

(1) The Air Force dispensary at Kwajalein, Marshall Islands, be reduced in function to correspond to that of an Army type dispensary, and that all hospitalization (in-patient treatment and care) at Kwajalein of Air Force, Navy, and Army patients not requiring evacuation therefrom be accomplished in the Navy dispensary at Kwajalein.

I.-ALASKA

It is recommended that:

(1) The 179th Station Hospital (Army) at the Air Force Base, Adak, Aleutian Islands, Alaska, be inactivated for the purpose of establishing an Air Force station hospital at that base. (The troop spaces involved have already been transferred to the Air Force by JAAFAR 1-11-50 of 5 November 1948, and the medical facility is now being operated by the Air Force.)

(2) All hospitalization (in-patient treatment and care) at Adak of Air Force, Army, and Navy patients not requiring evacuation therefrom be accomplished in the station hospital at Adak Air Force Base, Adak Island, Alaska.

(3) The Joint Chiefs of Staff be requested to review and reconsider the assignment made in 1946 to the Navy of responsibility for construction and future operation of a hospital at Adak for common utilization by the Armed Forces, and that reassignment or reaffirmation of that responsibility for construction and/or future operation of such a hospital of permanent type-construction at that location be made on the basis of the currently foreseeable peacetime requirements of the Armed Forces for hospitalization at that location. In this connection, it is recommended that any such reassignment of administrative responsibility for operation of this hospital be made to whichever Service (Army, Navy, or Air Force) is expected to have the largest military population and primary Service interests in the vicinity of Adak.

(4) The 202nd Station Hospital (Army) at Nome Air Force Base, Alaska, be inactivated for the purpose of establishing an Air Force station hospital at that base. (The troop spaces involved have already been transferred to the Air Force by JAAFAR 1-11-50 of 5 November 1948, and the medical facility is now being operated by the Air Force.)

(5) The 206th Station Hospital (Army) at Ladd Air Force Base, Alaska, be inactivated for the purpose of establishing an Air Force station hospital at that base. (The troop spaces involved have already been transferred to the Air Force by JAAFAR 1-11-50 of 5 November 1948, and the medical facility is now being operated by the Air Force.)

(6) The 183rd General Hospital (Army), Fort Richardson, Anchorage, Alaska, be inactivated, and that the troop spaces involved be transferred from the Army to the Air Force for the purpose of establishing an Air Force Station Hospital at that installation.

(7) An Air Force Base station hospital be established at Fort Richardson, Anchorage, Alaska, concurrently with the inactivation of the 183rd General Hospital at that place.

J.-GUAM

It is recommended that:

(1) All hospitalization (in-patient treatment and care) of Army, Navy, and Air Force patients on Guam be accomplished in one hospital as soon as this combined hospital patient-load has diminished to the point where the number of such patients can be adequately accommodated in one hospital installation on Guam.

(2) The present U. S. Naval Hospital, Guam, and the Army 22nd General Hospital, Guam, both of which are of wartime temporary construction which is rapidly deteriorating, and neither of which is capable of accommodating the present combined patient-loads of the two hospitals, both be continued in active operation until recommendation (1) above becomes feasible of accomplishment.

(3) Plans for and construction of a new U. S. Naval Hospital, Guam, which has been authorized by Congress (Public Law 653, 80th Congress), and for which an initial sum of $5,000,000 has already been appropriated to the Navy, proceed as soon as the size of the hospital required to meet future Armed Forces hospitalization needs on Guam can be appropriately determined in accordance with (4) below.

(4) The new U. S. Naval Hospital, Guam, be planned and constructed with the view to its utilization to meet the combined peacetime hospitalization requirements of the Armed Forces on Guam, and that such requirements be determined primarily on the basis of revised figures to be obtained from the Joint Chiefs of Staff as to the peacetime military population expected to be on Guam in the future and upon which such long-range plans for permanent type hospital construction must appropriately be predicated.

(5) Upon completion of construction of a new U. S. Naval Hospital on Guam, of adequate capacity to provide for the combined peacetime needs of the Armed Forces on Guam, all hospitalization for Armed Forces personnel, and for civilians who may be located at Guam by reason of their employment by or for the United States government, and for whom the Armed Services are responsible for providing local hospital treatment and care, be accomplished in this hospital.

(6) At the time of completion of the new U. S. Naval Hospital on Guam, any other Armed Forces hospital which may at that time be in operation on Guam then be disestablished and disposed of in such

manner as may be determined by the owning Service concerned.

NOTE: The above recommendations do not apply to or affect the Guam Memorial Hospital, Guam, which is a Civil Affairs activity and is operated for the primary purpose of providing hospitalization and medical services for the native population of Guam and other islands of the Pacific Trust Territory.

K.-SAIPAN

It is recommended that:

(1) The 53rd Station Hospital, Saipan, Marianas Islands, be reduced in function to that of an Army type dispensary, and that hospitalization (in-patient treatment and care) of station hospital type patients from this activity be accomplished in the Navy dispensary, Naval Operating Base, Saipan, M. I.

(2) General Hospital type patients from all Armed Forces activities at Saipan be evacuated to Guam for treatment in or for further evacuation from the appropriate hospital on Guam.

32. This report on "Programs for Hospitalization in the Armed Forces and for Improvement in the Utilization of Existing Hospital Facilities"

constitutes an increment of the Committee's report to you on its over-all assigrment.

33. The Committee unanimously recommends approval of this report and the early implementation of the recommendations contained therein.

PAUL R. HAWLEY, M. D.,
Chairman.

RAYMOND W. BLISS,
Major General, MC, USA,
The Surgeon General.

CLIFFORD A. SWANSON,
Rear Admiral (MC), U. S. Navy,
Surgeon General.

MALCOLM C. GROW,
Major General, MC, USA,
The Air Surgeon.

J. T. BOONE,
Rear Admiral (MC), U. S. Navy
Executive Secretary.